

CORRESPONDENCE.

VAS DEFERENS ANASTOMOSIS.

EDITOR ANNALS OF SURGERY:

IN the issue of the ANNALS for November Dr. Gwilym G. Davis reports a plastic operation upon a divided vas deferens. As a further contribution to the subject, I desire to call attention to an article concerning a method of securing anastomosis of such a vas, which was published by me in the *British Medical Journal*, January 2, 1904. The following is the method I used in the case under my care:

An oblique incision was made along the course of the inguinal canal similar to that used in the operation for the radical cure of an inguinal hernia, the spermatic cord was exposed, and the testis dislodged through the wound, carrying with it a swelling the size of a large pea which was situated in the course of the spermatic cord about one inch above the testis. This turned out to be a collection of semen confined in a fascial sheath between the ends of the divided vas deferens. The vas was found to be completely divided and its ends were separated for about half an inch.

The testicular end of the vas deferens was cut obliquely by means of a cataract knife. The distal or urethral portion of the vas was split up longitudinally for about one inch; this free end was further divided up for about half an inch from its extremity so as to provide two tails of equal size; in other words, each tail consisted of one-half of the longitudinally split vas deferens. The obliquely cut free end of the testicular portion of the vas was placed with its lumen in contact with that of the testicular portion, and was fixed by means of fine silk sutures as closely applied as the whipcord-like tube would admit. The two tails of the distal end were then enveloped round the testicular portion of the vas in order to counteract the disruptive force of the weight of the testis. Afterwards layers of fascia were wrapped round the anastomosed vas deferens and fixed by sutures.

I found it necessary to form the tails in order to secure a firm and permanent approximation of the divided end. It seemed to me that end-to-end anastomosis was not practicable, owing to the smallness of the tissues for suturing. Invagination of the ends was impossible on account of the rigidity and size of the walls of the vas deferens.

One can demonstrate the practicability of the above method of anastomosis of the vas deferens on the cadaver by injecting fluid along its lumen by means of a syringe.

As far as I know this case is unique, and I venture to record the method I devised on account of its being, I believe, a suitable operation in the conservative surgery of an injured vas deferens.

In this case there has occurred absolutely no atrophy of the testis.

J. LYNN THOMAS, C.B., F.R.C.S.

CARDIFF, ENGLAND.

To CONTRIBUTORS AND SUBSCRIBERS:

All contributions for Publication, Books for Review, and Exchanges should be sent to the Editorial Office, 386 Grand Ave., Brooklyn, N. Y.

Remittance for Subscriptions and Advertising and all business communications should be addressed to the

ANNALS OF SURGERY,
227-231 South Sixth Street,
Philadelphia.